FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032169

Facility Name: SHABBONA HEALTHCARE CENTER, INC.

Address: W. COMMANCHE STREET (Number) SHABBONA (City) 60550 (Zip Code)

County: DEKALB

Telephone Number: 815-824-2194 **Fax #** 815-824-2188

IDPA ID Number: 36-3503389

Date of Initial License for Current Owners: 04/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) NOSHIR DARUWALLA

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	91	Skilled (SNF)	91	33,306	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	91	TOTALS	91	33,306	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,815	5,328	1,479	8,622	8
9	SNF/PED					9
10	ICF	10,670	5,361		16,031	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,485	10,689	1,479	24,653	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.02%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NA

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,479

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	134,707	4,560	5,998	145,265		145,265		145,265			1
2	Food Purchase		114,162		114,162		114,162	(995)	113,167			2
3	Housekeeping	160,502	47,367		207,869		207,869		207,869			3
4	Laundry	61,481	8,117		69,598		69,598		69,598			4
5	Heat and Other Utilities			72,759	72,759		72,759	1,136	73,895			5
6	Maintenance	43,378		33,489	76,867		76,867	759	77,626			6
7	Other (specify):*											7
8	**TOTAL General Services**	400,068	174,206	112,246	686,520		686,520	900	687,420			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	836,593	9,492	1,793	847,878		847,878		847,878			10
10a	Therapy			36	36		36		36			10a
11	Activities	49,383	3,589	1,363	54,335		54,335		54,335			11
12	Social Services	23,149		1,651	24,800		24,800		24,800			12
13	Nurse Aide Training			2,135	2,135		2,135		2,135			13
14	Program Transportation			2,714	2,714		2,714		2,714			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	909,125	13,081	9,692	931,898		931,898		931,898			16
	C. General Administration											
17	Administrative	50,775		133,200	183,975		183,975	(38,239)	145,736			17
18	Directors Fees											18
19	Professional Services			23,486	23,486	(487)	22,999	7,237	30,236			19
20	Dues, Fees, Subscriptions & Promotions			15,548	15,548		15,548	(3,634)	11,914			20
21	Clerical & General Office Expenses	150,200	24,493	19,229	193,922		193,922	33,415	227,337			21
22	Employee Benefits & Payroll Taxes			210,925	210,925		210,925		210,925			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,525	1,525		1,525	179	1,704			24
25	Other Admin. Staff Transportation			179	179		179	1,811	1,990			25
26	Insurance-Prop.Liab.Malpractice			44,384	44,384		44,384	25	44,409			26
27	Other (specify):*							10,011	10,011			27
28	**TOTAL General Administration**	200,975	24,493	448,476	673,944	(487)	673,457	10,805	684,262			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,510,168	211,780	570,414	2,292,362	(487)	2,291,875	11,705	2,303,580			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SHABBONA HEALTHCARE CENTER, INC.
0032169
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS		
2	FOOD		

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	487	
19	PROFESSIONAL FEES		487

To reclass cost of appealing real estate taxes

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. #0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			14,982	14,982		14,982	83,594	98,576			30
31	Amortization of Pre-Op. & Org.							2,920	2,920			31
32	Interest			39,193	39,193		39,193	113,505	152,698			32
33	Real Estate Taxes			42,128	42,128	487	42,615	2,355	44,970			33
34	Rent-Facility & Grounds			299,754	299,754		299,754	(299,754)				34
35	Rent-Equipment & Vehicles			152	152		152		152			35
36	Other (specify):*											36
37	**TOTAL Ownership**			396,209	396,209	487	396,696	(97,380)	299,316			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		26,404	23,858	50,262		50,262	(215)	50,047			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,960	49,960		49,960		49,960			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		26,404	73,818	100,222		100,222	(215)	100,007			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,510,168	238,184	1,040,441	2,788,793		2,788,793	(85,890)	2,702,903			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,223	30		9
10	Interest and Other Investment Income	(376)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(495)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,220)	21		18
19	Entertainment				19
20	Contributions	(1,176)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(112)	21		24
25	Fund Raising, Advertising and Promotional	(2,405)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,165)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (726)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(85,164)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (85,164)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (85,890)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SHABBONA HEALTHCARE CENTER, INC.

ID# 0032169

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Trust Fees	(150)	20	2
3	Penalties			3
4	Prior year legal expenses	(1,015)	19	4
5				5
6				6
7				7
8				8
9				9
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87				87
88				88
89				89
90	Total	(1,165)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(495)				(500)							(995)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,136									1,136	5
6	Maintenance			759									759	6
7	Other (specify):*													7
8	**TOTAL General Services**	(495)		1,895		(500)							900	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			(38,239)									(38,239)	17
18	Directors Fees													18
19	Professional Services	(1,015)		2,786	5,466								7,237	19
20	Fees, Subscriptions & Promotions	(3,731)		97									(3,634)	20
21	Clerical & General Office Expenses	(8,332)	749	40,993	5								33,415	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			179									179	24
25	Other Admin. Staff Transportation			1,811									1,811	25
26	Insurance-Prop.Liab.Malpractice			25									25	26
27	Other (specify):*			10,011									10,011	27
28	**TOTAL General Administration**	(13,078)	749	17,663	5,471								10,805	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,573)	749	19,558	5,471	(500)							11,705	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	13,223	67,784	2,587									83,594	30
31	Amortization of Pre-Op. & Org.		2,920										2,920	31
32	Interest	(376)	219,333	2,174	(107,626)								113,505	32
33	Real Estate Taxes			2,355									2,355	33
34	Rent-Facility & Grounds		(299,754)										(299,754)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	12,847	(9,717)	7,116	(107,626)								(97,380)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(215)							(215)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**					(215)							(215)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(726)	(8,968)	26,674	(102,155)	(715)							(85,890)	45

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SHELDON WOLFE	50.00%	SEE ATTACHED		SEE ATTACHED		
ALBERT MILSTEIN	50.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 299,754	SHABBONA BUILDING ASSOC. LLC		$	$ (299,754)	1
2	V	32	INTEREST EXPENSE				258,833	258,833	2
3	V	30	DEPRECIATION				67,784	67,784	3
4	V	31	AMORTIZATION				2,920	2,920	4
5	V	21	REPLACEMENT TAX				749	749	5
6	V	32	INTEREST INCOME	38,052				(38,052)	6
7	V	32	GAIN IN PARTNERSHIP	1,448				(1,448)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 339,254			$ 330,286	$ * (8,968)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.W. MANAGEMENT	100.00%	$ 1,136	$ 1,136	15
16	V	6	REPAIRS AND MAINT.		S.W. MANAGEMENT		759	759	16
17	V	19	PROFESSIONAL FEES		S.W. MANAGEMENT		2,786	2,786	17
18	V	20	FEES, SUBSCRIPTIONS, DUES		S.W. MANAGEMENT		97	97	18
19	V	21	CLERICAL AND GENERAL		S.W. MANAGEMENT		40,993	40,993	19
20	V	24	EDUCATION AND SEMINARS		S.W. MANAGEMENT		179	179	20
21	V	25	TRANSPORTATION		S.W. MANAGEMENT		1,811	1,811	21
22	V	26	INSURANCE - PROPERTY		S.W. MANAGEMENT		25	25	22
23	V	27	PAYROLL TAXES		S.W. MANAGEMENT		7,236	7,236	23
24	V	30	DEPRECIATION		S.W. MANAGEMENT		2,587	2,587	24
25	V	32	INTEREST EXPENSE		S.W. MANAGEMENT		2,174	2,174	25
26	V	33	REAL ESTATE TAXES		S.W. MANAGEMENT		2,355	2,355	26
27	V						0		27
28	V								28
29	V								29
30	V	17	SALARY - SHELDON WOLFE		S.W. MANAGEMENT		94,961	94,961	30
31	V	17	SALARY - RONNIE KLEIN		S.W. MANAGEMENT		0		31
32	V	27	EMP. BEN.-SHELDON WOLFE		S.W. MANAGEMENT		2,775	2,775	32
33	V	27	EMP. BEN.-RONNIE KLEIN		S.W. MANAGEMENT		0		33
34	V								34
35	V	17	HOME OFFICE/MGMNT. FEES	133,200	S.W. MANAGEMENT			(133,200)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 133,200			$ 159,874	$ * 26,674	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	SFO ASSOCIATES	100.00%	$ 5,466	$ 5,466	15
16	V	21	CLERICAL & GENERAL		SFO ASSOCIATES		5	5	16
17	V	32	INTEREST		SFO ASSOCIATES		150,679	150,679	17
18	V	0					0		18
19	V	0					0		19
20	V	32	INTEREST	258,305	SFO ASSOCIATES		0	(258,305)	20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 258,305			$ 156,150	$ * (102,155)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	FOOD	$ 4,637	S&E	100.00%	$ 4,137	$ (500)	15
16	V	39	ENTERALS	1,073	S&E	100.00%	858	(215)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,710			$ 4,995	$ * (715)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	PHARMACY CONSULTANT	$ 1,650	PHARM-COR	100.00%	$ 1,650	$	15
16	V	10	PHARMACY	1,636	PHARM-COR	100.00%	1,636		16
17	V	39	PHARMACY MEDICARE A	26,404	PHARM-COR	100.00%	26,404		17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 29,690			$ 29,690	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, IN # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHELDON WOLFE	PRESIDENT	ADMIN	50.00	SEE ATTACHED	9	15.00	SWMGMNT	$ 94,961	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 94,961		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.W. MANAGEMENT
Street Address: 7434 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	H. O. / MGMT. FEE INC.	1,673,600	10	$ 14,270	$	133,200	$ 1,136	1
2	6	REPAIRS AND MAINT.	H. O. / MGMT. FEE INC.	1,673,600	10	9,537		133,200	759	2
3	19	PROFESSIONAL FEES	H. O. / MGMT. FEE INC.	1,673,600	10	35,007		133,200	2,786	3
4	20	FEES, SUBSCRIPTIONS, DUES	H. O. / MGMT. FEE INC.	1,673,600	10	1,218		133,200	97	4
5	21	CLERICAL AND GENERAL	H. O. / MGMT. FEE INC.	1,673,600	10	515,053	446,676	133,200	40,993	5
6	24	EDUCATION AND SEMINARS	H. O. / MGMT. FEE INC.	1,673,600	10	2,244		133,200	179	6
7	25	TRANSPORTATION	H. O. / MGMT. FEE INC.	1,673,600	10	22,760		133,200	1,811	7
8	26	INSURANCE - PROPERTY	H. O. / MGMT. FEE INC.	1,673,600	10	309		133,200	25	8
9	27	PAYROLL TAXES	H. O. / MGMT. FEE INC.	1,673,600	10	90,916		133,200	7,236	9
10	30	DEPRECIATION	H. O. / MGMT. FEE INC.	1,673,600	10	32,499		133,200	2,587	10
11	32	INTEREST EXPENSE	H. O. / MGMT. FEE INC.	1,673,600	10	27,315		133,200	2,174	11
12	33	REAL ESTATE TAXES	H. O. / MGMT. FEE INC.	1,673,600	10	29,591		133,200	2,355	12
13										13
14										14
15										15
16	17	SALARY - SHELDON WOLFE	AVG. HOURS WORKED	60	10	633,071	633,071	9	94,961	16
17	17	SALARY - RONNIE KLEIN	AVG. HOURS WORKED	60	7	60,000	60,000			17
18	27	EMP. BEN.-SHELDON WOLFE	AVG. HOURS WORKED	60	10	18,497		9	2,775	18
19	27	EMP. BEN.-RONNIE KLEIN	AVG. HOURS WORKED	60	7	11,246				19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,503,533	$ 1,139,747		$ 159,874	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SFO ASSOCIATES
Street Address: 7434 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	6,500,000	3	$ 20,901	$	1,700,000	$ 5,466	1
2	21	CLERICAL & GENERAL	NOTE RECEIVABLE	6,500,000	3	20		1,700,000	5	2
3	32	INTEREST	NOTE RECEIVABLE	6,500,000	3	576,127		1,700,000	150,679	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 597,048	$		$ 156,150	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S&E
Street Address: 3100 Commercial Avenue
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847-982-9300
Fax Number: (847-982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	DIRECT ALLOCATION			$	$		$ 4,173	1
2	39	ENTERALS	DIRECT ALLOCATION						858	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 5,031	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PHARMCOR
Street Address: 3116 S. Oak Park
City / State / Zip Code: Berwyn, IL 60402
Phone Number: (708-795-7701
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Pharmacy Consultant	Direct Allocation			$	$		$ 1,650	1
2	10	Pharmacy	Direct Allocation						1,636	2
3	39	Pharmacy Medicare A	Direct Allocation						26,404	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 29,690	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PHARMCOR
Street Address: 3116 S. Oak Park
City / State / Zip Code: Berwyn, IL 60402
Phone Number: (708-795-7701
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$ 1,650	1
2									1,636	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 3,286	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, IN(# 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/P SFO ASSOCIATES	X					$	$ 1,386,154			$	1
2	DUE TO/ FROM SHABB LLC	X									38,052	2
3												3
4												4
5												5
	Working Capital											
6	DUE TO/ FROM SFO ASSOC	X						1,808,108				6
7	INTEREST ON INS PAYMENTS		X								1,141	7
8												8
9	TOTAL Facility Related						$	$ 3,194,262			$ 39,193	9
	B. Non-Facility Related*											
10	Supplemental Schedule										113,506	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 113,506	14
15	TOTALS (line 9+line14)						$	$ 3,194,262			$ 152,699	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST SHABBONA BLDG	X					$	$			$ 258,833	1
2	INT. INCOME SHABBONA BL	X									(38,052)	2
3	GN IN PARTNER SHABBONA	X									(1,448)	3
4	INTEREST SFO ASSOC.	X									150,679	4
5	INTEREST SFO ASSOC.	X									(258,304)	5
6	INTEREST SW MGMNT	X									2,174	6
7	INTERSET INC SHABBONA										(376)	7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 113,506	21

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	36,229	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	40,578	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,349	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	40,134	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	487	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	44,970	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	37,214	8
	1996	31,343	9
	1997	34,597	10
	1998	34,503	11
	1999	38,223	12

2000 ACCRUAL = 36229x 1.1% =40134

ALLOCATION FROM SW MGMNT= 2355

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,200 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: SHABBONA LLC=87616
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 2,921
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 50,000	1
2	ALOC.SHABBONA ASSOC				2
3	TOTALS			$ 50,000	3

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	91		1994		$ 2,643,587	$ 67,784	39	$ 67,784	$	$ 437,850	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	2,650	84	20	177	93	2,109	9
10	Various			1990	65,810	2,812	20	3,290	478	34,840	10
11	Various			1991	20,535	460	20	1,027	567	11,217	11
12	Various			1992	5,466		20	273	273	3,371	12
13	Various			1993	13,848	393	20	685	292	5,059	13
14	Various			1994	39,334	1,009	20	1,967	958	13,342	14
15	Various			1995	13,479	309	20	674	365	4,736	15
16	STORAGE ROOM			1996	4,099	105	20	205	100	957	16
17	FIRE ALARM			1996	5,284		20	264	264	2,068	17
18	CONCRETE			1996	2,150	55	20	108	53	441	18
19	NEW GARAGE			1997	13,850	355	20	693	338	2,714	19
20	ELECTRICAL WIRING			1997	2,564	66	20	128	62	469	20
21	TOP SEAL-PARKING			1997	2,582	199	20	129	(70)	430	21
22	WATER MAIN			1998	934	24	20	47	23	141	22
23	HI GRADE PAINTS			1998	2,369	61	20	118	57	354	23
24											24
25	PAGE 12-1 REP TOTALS				43,462	1,300		1,379	79	6,062	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	PAGE 12A TOTALS				145,696	4,374		7,744	3,370	20,501	35
36	TOTAL (lines 4 thru 35)				$ 3,027,699	$ 79,390		$ 86,692	$ 7,302	$ 546,661	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REMODELING DINING RM			1998	2,550	65	20	128	63	288	9
10	REMODELING			1998	8,699	223	20	435	212	1,269	10
11	9 ROOM-S WING-ADJ			1998	14,826		20	741	741	2,119	11
12	12 ROOMS-S WING- ADJ			1998	18,456		20	923	923	2,481	12
13	16 ROOMS -N WING-ADJ			1998	39,758		20	1,988	1,988	5,666	13
14	REMODEL 10 ROOMS-ADJ			1998	21,366		20	1,068	1,068	3,138	14
15	REMODELING-NORTH WIN			1998	29,331	752	20	1,467	715	4,157	15
16	LINING FOR DRAPES			1998	659	17	20	33	16	99	16
17	HI GRADE PAINTS			1998	916	23	20	46	23	130	17
18	CURTAINS			1998	1,800	46	20	90	44	248	18
19	16 ROOMS -NORTH WING			1998		1,040	20		(1,040)		19
20	REMODELING 10 ROOMS			1998		561	20		(561)		20
21	9 ROOM-SOUTH WING			1998		392	20		(392)		21
22	12 ROOMS-SOUTH WING			1998		489	20		(489)		22
23	CONCRETE			1999	2,415	62	20	121	59	202	23
24	AIR HANDLER			2000	1,870	267	20	267		267	24
25	AIR HANDLER			2000	1,900	272	20	272		272	25
26	AIR HANDLER			2000	1,150	165	20	165		165	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 145,696	$ 4,374		$ 7,744	$ 3,370	$ 20,501	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
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30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	91		1995	SW MGMNT	$ 35,818	$ 918		$ 1,023	$ 105	$ 4,764	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATION SW MANAGEMENT			1995	3,675	190	20	219	29	972	9
10	ALLOCATION SW MANAGEMENT			1996	642	16	20	32	16	114	10
11	ALLOCATION SW MANAGEMENT			1997	924	115	20	66	(49)	149	11
12	ALLOCATION SW MANAGEMENT			1998	636	16	20	32	16	56	12
13	ALLOCATION SW MANAGEMENT			1999	1,767	45	20	7	(38)	7	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 43,462	$ 1,300		$ 1,379	$ 79	$ 6,062	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 310,179	$ 2,773	$ 10,056	$ 7,283		$ 266,303	37
38	Current Year Purchases	2,469	1,413	281	(1,132)		281	38
39	Fully Depreciated Assets	28,720		827	827		28,720	39
40								40
41	TOTALS	$ 341,368	$ 4,186	$ 11,164	$ 6,978		$ 295,304	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY BUSINESS	1998 OLDSMOBILE	1995	$ 21,506	$ 1,775	$ 718	$ (1,057)	5	$ 20,982	42
43										43
44										44
45										45
46	TOTALS			$ 21,506	$ 1,775	$ 718	$ (1,057)		$ 20,982	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,440,573	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 85,351	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 98,574	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 13,223	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 862,947	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SHABBONA HEALTHCARE CENTER, INC.
0032169
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
SHABBONA HEALTH CARE CTR	93,894	2,637	9,390	6,753	53,198
BUILDING COMPANY	209,300				209,300
SW MGMNT	6,985	136	666	530	3,805
TOTALS	310,179	2,773	10,056	7,283	266,303
LINE 29: CURRENT YEAR					
SHABBONA HEALTH CARE CTR	1,320	264	264		264
BUILDING COMPANY					
SW MGMNT	1,149	1,149	17	(1,132)	17
TOTALS	2,469	1,413	281	(1,132)	281
LINE 30: FULLY DEPRECIATED					
SHABBONA HEALTH CARE CTR	28,720		827	827	28,720
BUILDING COMPANY					
SW MGMNT					
TOTALS	28,720		827	827	28,720
TOTALS (Should Tie to Totals on Page 13)					
SHABBONA HEALTH CARE CTR	123,934	2,901	10,481	7,580	82,182
BUILDING COMPANY	209,300				209,300
SW MGMNT	8,134	1,285	683	(602)	3,822
TOTALS	341,368	4,186	11,164	6,978	295,304

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 152 Description: JUDY ICKS-MAINTENANCE EQUIPMENT
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$ 1,735	$ 1,735
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests			400	400
9	TOTALS	$	$	$ 2,135	$ 2,135
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 8,424	$		$ 8,424	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,395			1,395	2
3	Licensed Recreational Therapist	39-3	hrs			26			26	3
4	Licensed Physical Therapist	39-3	hrs			11,321			11,321	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				26,404		26,404	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**					2,692			2,692	13
14	TOTAL			$		$ 23,858	$ 26,404		$ 50,262	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	RADIOLOGY SERVICES	572
2	LABORATORY SERVICES	2,120
3		
4		
5		
6		
7		
8		
9		
10		
		2,692

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 259,310	$ 259,310	1
2	Cash-Patient Deposits	1,168	1,168	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	294,340	294,340	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		27,645	5
6	Prepaid Insurance	20,787	20,787	6
7	Other Prepaid Expenses	143	87,759	7
8	Accounts Receivable (owners or related parties)	75,743	75,743	8
9	Other(specify): See supplemental schedule	109,368	109,368	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 760,859	$ 876,120	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		2,643,587	14
15	Leasehold Improvements, at Historical Cos	314,063	314,063	15
16	Equipment, at Historical Cost	171,306	380,606	16
17	Accumulated Depreciation (book methods)	(220,269)	(867,419)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	3,000	3,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,000)	(22,045)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 265,100	$ 2,501,792	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,025,959	$ 3,377,912	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 40,343	$ 40,343	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,256	1,256	28
29	Short-Term Notes Payable	560,892	1,389,740	29
30	Accrued Salaries Payable	33,048	33,048	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,971	3,971	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,134	40,134	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	16,777	16,777	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 696,421	$ 1,525,269	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,808,108	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,808,108	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 696,421	$ 3,333,377	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 329,538	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,025,959	$ #REF!	48

*(See instructions.)

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. **#** 0032169 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Employee Loans	7,546	7,546
Employee Payroll Advance	1,467	1,467
Short Term Loan Exchange	100,355	100,355
	109,368	109,368

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses	16,777	16,777
	16,777	16,777

OTHER NON CURRENT ASSETS:

Construction In Progress
Utility Deposit
Loan Costs

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 464,541	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 464,541	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	14,997	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(150,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (135,003)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 329,538	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	SHABBONA HEALTHCARE CENTEF #	0032169	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		464,541
Adjustments:		
		-
		-
		-
Rounding Adjustment		
Total adjustments		-
Balance - Beginning of Year		464,541
Equity(Deficit) from Page 17 Col 1		329,538
Related Party		
Equity(Deficit)	-293969	
Income	8966	
		(285,003)
Combined Equity - End of Year		44,535

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,773,377	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,773,377	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,790	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,790	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	4,250	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,307	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	12,449	21
22	Laundry	6,168	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 26,174	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	376	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 376	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,073	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,073	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,803,790	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	686,520	31
32	Health Care	931,898	32
33	General Administration	673,944	33
	B. Capital Expense		
34	Ownership	396,209	34
	C. Ancillary Expense		
35	Special Cost Centers	50,262	35
36	Provider Participation Fee	49,960	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,788,793	40
41	**Income before Income Taxes (line 30 minus line 40)****	14,997	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 14,997	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not completed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SHABBONA HEALTHCARE CENT # 0032169 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	State Replacement Tax Refund	1,073
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	1,073

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 43,112	$ 20.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,166	10,531	201,435	19.13	3
4	Licensed Practical Nurses	7,413	8,863	151,880	17.14	4
5	Nurse Aides & Orderlies	35,955	43,132	440,166	10.21	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,342	4,887	49,383	10.10	10
11	Social Service Workers	2,002	2,138	23,149	10.83	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	18,341	8.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,757	16,873	116,366	6.90	15
16	Dishwashers					16
17	Maintenance Workers	4,920	4,958	43,378	8.75	17
18	Housekeepers	18,300	20,724	160,502	7.74	18
19	Laundry	8,440	8,824	61,481	6.97	19
20	Administrator	2,000	2,080	50,775	24.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,936	9,057	150,200	16.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	120,231	136,227	$ 1,510,168 *	$ 11.09	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 5,998	1-3	35
36	Medical Director				36
37	Medical Records Consultant	1	120	10-3	37
38	Nurse Consultant	1	24	10-3	38
39	Pharmacist Consultant	96	1,650	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	1	36	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	1,363	11-3	44
45	Social Service Consultant	96	1,651	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	387	$ 10,842		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY ICKES	Administrator	0	$ 50,775
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 50,775

B. Administrative - Other

Description	Amount
SW MANAGEMENT MGMNT FEE	$ 72,000
SW MANAGEMENT HOME OFFICE FEE	61,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 133,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
WINSTON & STRAWN	LEGAL	3,916
ALLAN LEFKOVITZ	LEGAL	487
ALAN H. COOPER	LEGAL	30
FRR	ACCOUNTING	19,053
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 23,486

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,359
Unemployment Compensation Insurance	10,216
FICA Taxes	115,529
Employee Health Insurance	55,759
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday expense	987
Misc.Employee Benefits	75
TOTAL (agree to Schedule V, line 22, col.8)	$ 210,925

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,134
Health Care Worker Background Check	
(Indicate # of checks performed 10)	116
Association Dues	3,886
Dues/Subscriptions	537
licenses & Permits	1,064
Advertising and Promotion	2,405
Alloc SW Mgmnt	97
Public Notary Fees	80
Less: Public Relations Expense	( )
Non-allowable advertising	(2,405)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,914

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,525
Alloc SW Mgmnt	179
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,704

**See instructions.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SHABBONA HEALTHCARE CENTER, INC. # 0032169 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **4027 Illinois Council on LTC**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NONE** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **49,959**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ Has any meal income been offset against related costs? **NA** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%of line**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw